ReviveMed

Zed3 Medical Group

PSYCHIATRY REFERRAL

PATIENT DETAILS

First Name:		Surname:
Address:		Suburb/City:
State:	Postcode:	Date of Birth:

DVA No:	Medicare No:	ADF DRN:

Diagnosis/es: ☐ PTSD* ☐ MDD* ☐ GAD* ☐ Substance misuse* ☐ Musculoskeletal injuries*
☐ Pain Other*:

Treatment to date:

Psychologist:	☐ Present	☐ Not present
Other supports:	☐ Present	☐ Not present

SUICIDALITY
☐ High
☐ Low
☐ Acute
☐ Chronic

Preference of Service Location: ☐ Canberra ☐ Wagga Wagga ☐ Adelaide

Further comments:

Referring:	Provider No:	Contact number:
Address:		Suburb/City:
State:	Postcode:	
Email:		

GP details:
Psychologist details:

In sending this referral, you acknowledge that if your patient is eligible to receive ketamine infusion therapy with ReviveMed, that you will be required to sign and participate in a Collaborative Care Arrangement (CCA). The CCA facilitates the sharing of information and best practice care for patients.

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